WestGate
Family Medicine
2015 Dean St. Unit 2
St Charles IL 60174

Telephone: 630 584 2400 Fax: 630 584 2404

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
THIS MUST BE COMPLETED IN FULL TO BE VALID

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient name	**Date of birth**	**Social Security number**
Address (street, city, state, zip code)		**Telephone number**

AUTHORIZE THE FOLLOWING:

RELEASE INFORMATION FROM:	**SEND INFORMATION TO:**
Name: _____	**Name:** _____
Address: _____	**Address:** _____
City/State/Zip _____	**City/State/Zip** _____

The following medical records are to be released:

___Complete record
Other (specify) _____

Treatment dates:
_____
Reason for request
_____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral and mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand that the revocation will not apply to information already released based on the authorization.

Expiration: unless otherwise revoked, this authorization will expire on the following date, event or condition: (If I do not specify the expiration date, event or condition, this authorization will expire in six months)._____

Faxing: I do specifically consent to transmission of my MEDICAL RECORDS via fax if 10 pages or less Yes____No____

Signature _____ **Date** _____